

# MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037768

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9733

FILED OCT 4 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>16 days</b>	c. CITY OR TOWN <b>Dupo</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis-Little Rock Hospital, Inc.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>409 N. 2nd St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ralph Monroe Lemmon</b>			4. DATE OF DEATH Month Day Year <b>September 29 1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-17-1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Penr. Pipefitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	9. AGE (last birthday) <b>68</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <b>Washington INDIANA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>James LEMMON</b>		13b. MOTHER'S MAIDEN NAME <b>Tulian POTTS</b>	
14. NAME OF HUSBAND OR WIFE <b>Alice</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)	
16. SOCIAL SECURITY NO. <b>3</b>		17. INFORMANT <b>Alice LEMMON</b> Address <b>Dupo Illinois</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronic failure, chronic Pulmonary Emphysema</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>5271</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs 4 mos</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Sept. 14, 1963</b> to <b>Sept. 29, 1963</b> and last saw him alive on <b>Sept. 28, 1963</b> Death occurred at <b>9:45 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>R. S. Newman, M.D.</b>		22b. ADDRESS <b>St. Louis-Little Rock Hosp. Inc. 1755 S. Grand Blvd.</b>	
22c. DATE SIGNED <b>9/30/63</b>		22d. LOCATION (City, town, or county) (State) <b>Wood River, Illinois</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9/30/63</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Lawn</b>		23d. LOCATION (City, town, or county) <b>Wood River, Illinois</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Dashner Funeral Home, Dupo, Ill.</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 30 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Ed Smith, M.D.</b>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

USE BLACK INK  
OR  
TYPEWRITER RIBBON

VS 300  
Rev. 4/59

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Harold A. Ashme*

Licensed Embalmer No. 4621

P. O. Address Daysville, Me.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.